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ABSTRACT

Research findings have confirmed the view that if mental health practice is to be relevant and responsive to minorities, it must consciously and deliberately take into account their ethnic heritage and culture. The world views of ethnic minorities, or the ways in which they perceive their relationship to nature, institutions, other people, and objects, can be divided into four major categories. The bicultural/multicultural world view draws upon multiple sources of culture and socialization experiences, from both traditional cultures and the mainstream cultural system. The acculturated/assimilated world view involves the acquisition of beliefs, attitudes and behaviors of a social group of which one is not a natural member. The native-oriented/traditional world view is based on patterns of behaviors, values, and beliefs of a group that shares a common historical past. The transitional/marginal world view refers to types of individuals who are suspended between their own ethnic identity and the mainstream culture. The process of identifying specific world views can be achieved by the cross-classification of two dimensions: the level of intensity and value an individual places on his/her own culture and identity; and the level of intensity and value placed upon involvement and participation in the mainstream culture. In the context of mental health, this typology can serve at least three main functions. It can be used for assessing the basic orientation of ethnic minorities to their own group and to the larger society; for providing a framework for considering related concerns such as values, language, beliefs, and behaviors; and for avoiding the errors of assuming that racial and ethnic minorities are unicultural, or that ethnic differences are "minor" variations on the mainstream culture. An 11-page bibliography concludes the document. (NRB)

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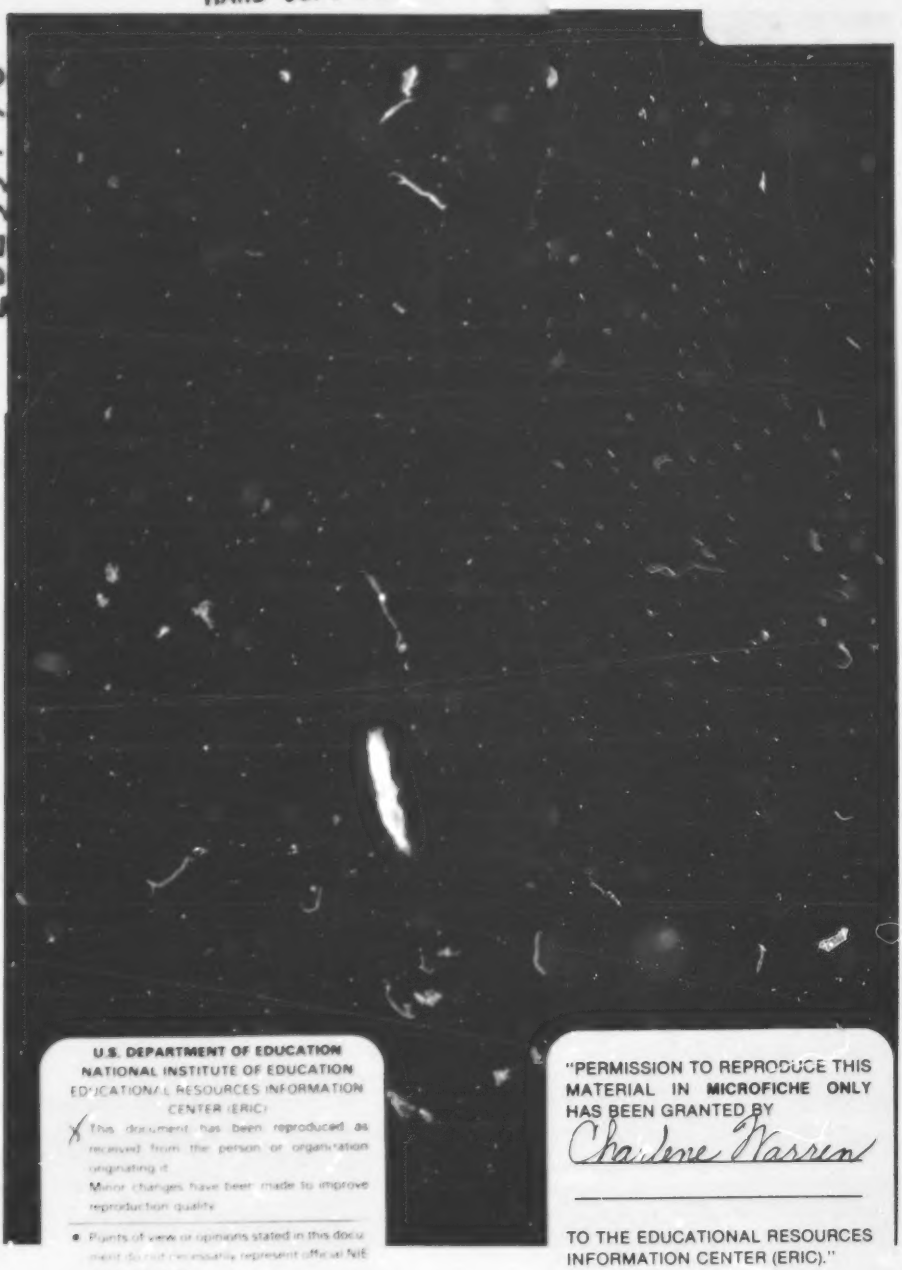

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THE CHALLENGE FOR MENTAL HEALTH MINORITIES AND THEIR WORLD VIEWS

THE CHALLENGE FOR MENTAL HEALTH

MINORITIES AND THEIR WORLD VIEWS

By

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Robert L. Sutherland Professor
in
Mental Health and Social Policy
The University of Texas at Austin
School of Social Work

The Second Annual Robert L. Sutherland Lecture
The University of Texas at Austin

Thursday, November 3, 1983
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Foreword

The Robert Lee Sutherland Chair in Mental Health and Social Policy was established in 1981 by gifts from Texas and Southwest foundations and from other friends and admirers of Bob Sutherland's unwavering devotion to positive mental health, research, effective professional service, voluntarism, and philanthropy. As long-time Director and President of the Hogg Foundation for Mental Health he touched many lives, some very directly by a close personal association in pursuit of ideas and ideals and numerous others by influencing the nature of services and policies at local, state, and national levels. He had a profound effect, as well, on the development and support of the School of Social Work at The University of Texas at Austin. We are grateful for the opportunity and responsibility the Robert Lee Sutherland Chair gives us to continue through permanently-endowed service the ideals he so ably represented.

Richard A. English, the current holder of the Sutherland Chair, is on leave of absence from the University of Michigan where he is a Professor of Social Work and formerly Associate Vice President for Academic Affairs (1974-1981). During this period he has also served as President of The Council on Social Work Education, the standard-setting and accrediting organization for graduate and undergraduate professional social work education in the United States.

Dr. English's Sutherland lecture is a continuation and extension of his research activities on the educational and occupational aspirations and expectations of Black and white youth, Black families, and socio-historical research on Black families in the 19th century and early 20th century. He has published in the areas of minority students in higher education, Black families, ethnic group relations, mental health, and human service organizations. He is co-author of a forthcoming book, *Beyond Pathology: Marriage and the Family Among Black Americans 1865-1980.* In 1983 he co-authored a three-year National Institute of Mental Health–Mental Health Professions grant to increase the number of minority mental health professionals, specifically Black and Hispanic.

Dr. English received the A.B. degree with honors (in history, 1958) from Talladega College, M.A. (history, 1959), MSW (social work, 1964)

and Ph.D. (sociology and social work, 1970) degrees from the University of Michigan. He has been a fellow of the American Psychological Association and National Institute for Education (1981-1982), a visiting scholar to Taiwan and the People's Republic of China (1980), a visiting professor at Howard University (1982-1983), and visiting professor at Paul Baerwald School of Social Work, Hebrew University, Jerusalem, Israel (1975). He received the National Association of Black Social Workers Distinguished Service Award (1983) and was a Woodrow Wilson Fellow (1958-1959).

We are enriched by Dr. English's presence as a distinguished visiting professor for 1984 to 1985 and by his scholarly and professional activities in a vital area of knowledge and service.

Martha S. Williams
Dean
School of Social Work
The University of Texas at Austin

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Introduction

Between "the years when a crippling depression was just about to end and World War II was about to begin" (Drake, 1940:vi), the American Council on Education established the American Youth Commission (1935). A special advisory committee of the Commission was appointed in 1938 to assist in organizing a major research investigation of the conditions, needs and distinctive problems of "growing up Black in America." The study was designed to determine the effects upon the socialization and personality development of Black youth between the ages of 16 and 24, and primarily of lower socioeconomic status, and their adaptation to a hostile environment. Between 1935 and 1940, hundreds of thousands of American youth were unemployed and the proportion of Blacks among them was greatly beyond their number in the population. *(Note 1)*

The American Council on Education project produced four major studies conducted concurrently in different geographic regions of the country. A distinguished group of social scientists was assembled for this task:

> Allison Davis and John Dollard studied the effects of caste and class discrimination upon eight Black youth in Natchez and New Orleans published in their book *Children of Bondage (1940)*;
>
> E. Franklin Frazier concentrated on youth and communities in the Upper South and selected the cities of Washington, D.C. and Louisville, Kentucky. The result of his work was *Negro Youth at the Crossways (1940)*;
>
> Charles S. Johnson produced a classic study on rural Southern youth coming of age in his book, *Growing Up In The Black Belt (1941)*. Johnson studied the socialization and maturation processes of youth in the rural South: six counties including Bolivar and Coahoma in Mississippi, Macon and Madison in Alabama, Green in Georgia and Shelby in Tennessee;

W. Lloyd Warner collaborated with one of his graduate students, Buford H. Junker, and a Black psychoanalyst, Walter A. Adams, in a study of the personality development of Black youth in the inner city of Chicago. The results were published in the book *Color and Human Nature (1940).*

At the center of this unprecedented and historic social science research activity was Professor Robert L. Sutherland. The studies of "Negro Youth" were begun under Homer P. Rainey who was the first director of the American Youth Commission and who subsequently became the President of The University of Texas. In the initial planning of these studies, Dr. Rainey invited the assistance of Professor Sutherland who at the time was a professor of sociology at Bucknell University. Professor Sutherland later served as associate director of the Commission with responsibility for the studies of "Negro Youth." He contributed the final volume to the study which included a summary of the major findings of the entire project and a program of recommendations for education, religion, and social work (Sutherland, 1942).

These historic studies served to focus (if only too briefly) the nation's attention upon the special needs and problems of a substantial majority of American Black children and youth coming of age at a time in which the "American Dream" was simply not accessible to them. The solutions recommended by Professor Sutherland and his colleagues at the Commission were certainly advanced for the times. These empirically derived recommendations were well conceived, yet naive by contemporary standards. They fell short in addressing fundamental structural problems of racism, the lack of occupational and educational opportunities affecting Black children and youth.

Although the American Council on Education "Youth Studies" and policy recommendations did not have an immediate and demonstrable impact on societal changes which could have significantly altered the quality of life for Black children, youth and their families, they were, however, precedent setting in two (2) respects. First, they demonstrated concretely the ways by which closer collaboration could proceed between social scientists and public policy makers. Second, they made a significant contribution to an emerging scientific study of the Black experience, particularly children and families.

The research of Kenneth and Mabel Clark is exemplary of both these traditions. In 1939-1940, the Clarks published their famous doll studies on Black preschoolers. These studies focused on Black children as victims of racial discrimination. Their results showed that Black children as compared with Anglo children positively evaluated, and more often chose as a preferred playmate, an other-race doll. These findings were interpreted as evidence for a developing "self-hatred" identity conditioned by environmental influences. The Clarks' studies were cited in the famous footnote eleven of Chief Justice Earl Warren's brief on the 1954 Supreme Court decision *Brown v. Board of Education. (Note 2)*

Another major legacy related to the pioneering efforts of Professor Sutherland and his colleagues occurred in more recent times. In 1969, the Congressional Joint Commission on Mental Health of Children (1970), recognizing that the mental health problems of minority children were severe enough to deserve special attention, established the Committee on Children of Minority Groups. In its final report, the Commission identified racism as a major contributing factor to impaired self-image among minority children.

When the youth studies came to an end, Floyd W. Reeves, director of the American Youth Commission, paid tribute to Dr. Sutherland's humanitarianism and his future role in an emerging research tradition in mental health. He praised Dr. Sutherland's leadership of the American Youth Commission Study Project and acknowledged "... his unfailing concern not only for method and materials of research but also for the human aspects of the problems with which the studies are concerned" (Sutherland, 1942:vii).

It is quite fitting, therefore, that the subject of my lecture this evening is closely allied with a life-long interest of Professor Robert L. Sutherland—the welfare and well-being of his fellow Americans. He was a leader and a catalyst—a man who helped people and programs develop to their heights. *(Note 3)*

I am proud to share in this fine legacy which the School of Social Work and The University of Texas have memorialized in the Robert L. Sutherland Chair in Mental Health and Social Policy.

My presentation this evening focuses upon two critical issues in mental health: ethnic minorities and their world views. It will be my

contention that ethnicity and individual and group level world views constitute a crucial body of knowledge and a valuable resource for mental health practice.

First, I will review some of the recent research findings related to ethnic minorities and their mental health and identify some implications for mental health practice and education. Next, I will present some critical ethnic factors in mental health practice. This discussion will be followed by a consideration of the world views of minorities in relation to mental health issues. Finally, I will offer a few closing remarks.

Social Science Research and The Mental Health of Ethnic Minorities

During the past quarter of a century, considerable debate and discussion have taken place about the mental health of Afro-Americans and the treatment of the mental illnesses that afflict them (Gary, 1978). In the more recent past, parallel concerns have been expressed about other minorities of color—Asian and Pacific Americans, Hispanics, and American Indians (Sue and Morishima, 1982; Munoz and Endo, 1982; Ochberg and Brown, 1973: 555–579; President's Commission on Mental Health, 1978b).

The classic demographic studies of mental health in the late 1950s and early 1960s demonstrated the relationship between social class and mental health. In so doing, these studies made clear that some groups were more vulnerable to mental disorders than others. (Hollingshead and Redlich, 1958; Hollingshead and Rogler, 1962; Srole, L., et. al., 1962; Reisman, Cohen and Pearl, 1964). Twenty years later, a similar recognition of the relationship between racism and mental health was made. *(Note 4)*

During the intervening years, researchers, practitioners, and others advocated for the necessity of using alternative intervention strategies in the development of human services for minorities of color and for the conduct of research which took the minority oppressed condition into account. Yet, it was not until 1978 that an authoritative body, the President's Commission on Mental Health, recognized the limitations in promoting human welfare when cultural and minority group experiences are not taken into account. It had been only seven years earlier when the Joint Commission on Mental Illness and Health (1971) published the document *Action for Mental Health* and continued a long-standing tradition in the mental health movement of ignoring or underplaying racial aspects of the field. Although the Joint Commission found evidence that racial factors did produce stress on racial and ethnic minority members, it did not consider improvement of racial conditions in the domain of preventive psychiatry (Gary, 1968; President's Commission on Mental Health, 3:78; Kramer, 1973: 3–23; Sue and Morishima, 1982).

Despite the legacy of racism and prejudice in the mental health disciplines, there is now in the United States a substantial body of knowledge about minorities, their mental health needs and problems, their experiences with the mental health field, and the response of mental health professionals to them and their problems. What this body of knowledge reveals, however, is frequently complex, contradictory, perplexing, and paradoxical. Therefore, the application of this body of knowledge to mental health practice presents an enormous challenge. There are some issues involving the status of minorities and their mental health for which there is high empirical and value consensus based on recent research evidence. To illustrate, we know: *(Note 5)*

1. In the United States, racism is one of the many and complex stressors for racial and ethnic minorities.

2. Black men proportionately have the highest rate of mental disorders as compared to other age and racial groups, especially for those between the ages of 18 and 34.

3. The treatment rates for Black women are relatively low until the age of 35 when their rates increase significantly.

4. Many Black adults are under the care of a variety of institutions, i.e. correctional, mental hospitals, residential treatment centers, chronic disease hospitals, nursing homes for the elderly and dependent. They are more likely to be in mental institutions than Anglos and twice as likely to suffer fatal consequences from psychoses and neuroses.

5. Blacks are more likely to be committed for custodial care in mental hospitals somewhat sooner than are Anglos. Their admissions to psychiatric institutions are less likely to be voluntary, and they are less likely to be committed to institutions by a spouse or offspring.

6. Racial and ethnic minorities tend to receive less preferred modes of treatment, to underutilize services, and to terminate psychiatric services prematurely.

7. The type of treatment received in mental health agencies for ethnic minorities is different than that for Anglos. For example, diagnoses are less accurate; disposition of cases is more nonspecific; minorities are more likely to be seen for diagnostic purposes and are less likely to be selected for insight-oriented therapy than Anglos.

8. Although programs of deinstitutionalization significantly lowered the rates of institutionalization, the relative declines were less for Blacks than for Anglos.

9. Finally, social science research has revealed that failure to take into account the cultural characteristics of minorities constitutes a significant detriment to effective service delivery.

Implications of Past Research For Mental Health Practice and Education

These findings should not be construed to mean that all Black Americans or other ethnic minority groups are at the same level of risk. Rather they are useful in constructing some general implications for mental health practice and education.

First, there are some members of minority groups who are at greater risk than others, e.g. Black men.

Second, there are some environmental conditions to which minorities are most likely to be exposed and which conspire to place them in a vulnerable and helpless position in warding off mental illness. In other words, many Black Americans are less prepared to cope with mental disorders given their socioeconomic and political position and their difficulties in acquiring quality mental health services.

Third, cross-cultural knowledge, understanding, and communications can greatly influence the outcome of the therapeutic encounter.

Fourth, although the mental health community has responded to the research evidence which reveals that ethnic minority group clients receive inferior and discriminatory forms of treatment, when opportunities for treatment are equalized, the outcomes are not necessarily equalized. Individuals who value equal treatment opportunities (that is, seeing that discrimination in services does not exist) may unwittingly perpetuate unequal outcomes. Those who advocate equal

outcomes (that is, seeing that minority groups are as likely as Anglos to benefit from mental health services) may have to discriminate by treating some groups differently because of cultural differences. Particularly for those clients who markedly differ from mainstream Americans, some special treatment may be necessary (Sue and Morishima, 1982; Cheetham, 1982).

Fifth, despite the increased practice and empirically based information on the provision of culturally relevant service to racial and ethnic minorities and the vast and growing literature on minority culture and mental health, the core mental health disciplines of social work, psychology, psychiatry, and psychiatric nursing have not, in their educational programs, adequately prepared practitioners for effective practice among people of color. Having the knowledge does not necessarily provide directions for action including the types of change strategies that are effective (Sue and Morishima, 1982; Chunn, Dunston and Ross-Sheriff, 1983).

Misconceptions, distortions and racist stereotypes of ethnic minorities further complicate this process. A few examples will serve to illustrate this problem. The belief by policy makers and practitioners that the Black community tolerates and absorbs a greater degree of "deviant" behavior than do non-Blacks is often presented as a truism. It simply is not true! The high value placed upon children and strong kinship bonds, for example, supercedes the condoning of out of wedlock childbirth and results in a high proportion of Black families providing assistance to unmarried adolescent parents and their children (Chilman, 1979; Stack, 1974).

Another example of a misconception is the belief that oppressive social and economic conditions necessarily cause minorities to have low self-esteem and engender a sense of powerlessness. Rather, as the recent research evidence demonstrates, low self-esteem and powerlessness among Blacks have been found to be associated with geographical location, the intensity of exposure to racism and negative personal valuations, the extent of strong family or group relationships, and socioeconomic status. Not all Afro-Americans have had the same experience with racism, negative valuations and deficits in opportunities and resources. Many have been cushioned by their families and friends against negative effects based on skin color and racial origin.

Hence, many such persons tend not to be afflicted by feelings of low self-esteem and powerlessness (Powell, 1982; Irvine and Irvine, 1983; Lewis, 1975; Barnes, 1982).

On the other side of the ledger, there is a widely held conception of Afro-Americans and other ethnic minorities which is grounded in hard evidence. This is the conceptualization that in times of need ethnic minorities tend to use their extended kin and other primary group relations more often than traditional mental health services. The research evidence does support this contention. Ethic minorities do tend to consult family, friends, physicians and clergy before turning to a mental health agency, if at all (Gary, 1978; McAdoo, 1978). Yet, when they interact with the mental health system, their preferences for primary group or community-based treatment of emotional and mental problems are largely ignored. Instead, the mental health system tends most often to rely upon institutional commitment as a preferred mode of response (Allen and Stukes, 1982).

Since Blacks and other ethnic minorities have developed and utilize extensive primary group sources in coping with the exigencies of life, the injunction should not be to make the mistake of assuming that bureaucratic mental health services can be of no value to them or that they are not motivated or interested in using these services. Past experience suggests, however, that when bureaucratic mental health service programs come into the picture, primary group helping resources are disrupted and all too frequently disregarded. Hence, the widespread agreement amongst mental health professionals over the importance of "natural" or primary group support systems in mental health is subverted.

The over-reliance upon primary group resources for coping with life stresses and other mental health related problems is not without its peril. Consideration should be given to the costs and benefits associated with the utilization of informal social support networks for both helper and seeker. Quantitative and ethnographic studies reveal that help-seeking patterns among Blacks are highly complex and their consequences are not always self-evident. For example, the participation and commitment to a closely knit kinship-based system of cooperative domestic exchanges and obligations may be extremely rewarding on the one hand, but on the other hand may lead to the

sacrifice of critical life goals such as social and geographic mobility and even marriage. Moreover, when compliance with a norm of reciprocity in informal social support networks is not possible, kinship relations may be strained. The helper is often deprived of a source of mutual support and the seeker may suffer the strain of being a recipient of constant support (Stack, 1974; Gary, et.al., 1984).

Hence, the matter of seeking help and relying extensively and solely upon one's extended kin and friends is not a simple or straightforward matter. Care should be taken, therefore, in the assessment of both indigenous patterns of helping networks in ethnic minority populations, as well as the formal bureaucratic mental services available.

Theory suggests that when used in some combination or sequential pattern, the effectiveness of family, extended kin resources, indigenous community-based care-givers, and bureaucratic mental health services is maximized. (*Note 6*) Each makes a unique and specialized contribution to the solution of the individual problem. The help received from extended kin and friends is different in type, quality, level of expertise, and availability than the help received from organized mental health services. Further, when both the kinship system and the bureaucratized mental health system are coupled with community networking, self-help groups, neighborhood groups and programs, and community school programs, the goal of improving mental health services for minority populations has been greatly advanced (Litwak and Dono, undated). Above all, when the mental health system understands and takes into account, in their service delivery systems, indigenous mechanisms of managing emotional stress and mental illness such as family and friendship networks and patterns of help-seeking, they will have greatly maximized the mental health of ethnic minorities.

A Paradigm for Understanding The Mental Health of Racial And Ethnic Minorities

The development and coherence of mental health policy and treatment is greatly advanced when considered from the vantage point of minorities rather than a mainstream Anglo perspective. Social science theory and research on the relationship of intervening mechanisms linking societal structures to individual mental health provides a conceptual framework for analyzing the dynamics of ethnic minority personal environments, including their networks of social support, and the larger society. (*Note 7*) For example, it is both significant and useful to know that racism, discrimination, poverty, migration, urbanization, and similar factors are related to mental health. However, we have made significant strides in the treatment and prevention of mental illness when we are able to specify more definitively the complex interactions between mental disorders and these larger-than-life social facts. The policy and treatment goals for mental health delivery systems, therefore, should be to identify specific structures and resources in racial and ethnic communities which mediate between the larger society and individual mental health and those which are helpful in alleviating stressors leading to mental disorders.

These goals are facilitated in large measure by taking ethnicity into account in service delivery. Recognition is given to the unique experiences and consequences of ethnic identity and to the functions and contributions ethnicity makes to mental health. The world view of minorities is shaped in significant ways by ethnic experiences. The role it plays in mental health outcomes for ethnic minorities is crucial. For example, one's world view may play an influential role in the decision making process involving critical life events, such as educational, occupational, and marital choices, and the extent to which one relies upon ethnic contacts and resources in making those choices.

In the final parts of this paper, the implications of ethnicity and world views for mental health delivery systems serving ethnic minority clients will be further specified.

The Role of Ethnic Factors in Mental Health

When Nathan Glazer and Daniel Moynihan (1963) suggested in the early 1960s that "the point about the melting pot is that it did not happen," ethnic pride and self-consciousness had once again emerged as a major theme in American life. Unlike previous waves of ethnic consciousness in American history, this one was different. *(Note 8)* Afro-Americans were its pioneers. It seemed to have gone beyond the pattern of adaptation to hard times which was so characteristic of previous waves of ethnic ascendency. This wave of ethnic pride was typified by an exploration and clarification of group and individual identity issues and in fostering group identity. These efforts influenced other ethnic groups to examine their own ethnic experiences, to advocate on behalf of their own needs, and to reject conformity to the "melting pot" ideal which was so central to previous waves of ethnic consciousness.

This new wave of ethnicity seemed to have had the effect of putting to rest the conventional wisdom that all immigrant groups in the country were already assimilated. Those who were not were considered to be in circumstances which made assimilation difficult if not impossible. As for Afro-Americans, this new campaign of ethnic pride effectively challenged the view that their so-called "inadequate" culture poorly prepared them for assimilation into the American mainstream. *(Note 9)*

Rather than decline in significance, ethnic identity has been on the ascendency in America, not only among minorities of color but Anglo ethnic groups as well. Therefore, the problem of addressing special mental health concerns of ethnic minorities will not go away and can be expected to become even more pressing as the numbers of new ethnic minority immigrants increase in the U.S. population, as these immigrants continue to show diversity in education, mobility, social and economic needs, and ethnic consciousness. Hence, the question as to whether minorities ought or ought not to remain ethnically distinct is irrelevant. The fact is that they are!

Unfortunately, because ethnicity has been historically associated with racism, conflict, group self-interests, and ideological dilemmas, its virtues and positive aspects have been overlooked by social workers, psychologists, psychiatrists, and other mental health profes-

sionals (Jenkins, 1981; Cheetham, 1982). In a recent cross-national study of agencies serving racial and ethnic populations in the United States, Israel, West Africa, and Great Britain, it was reported that "what worked" in these agencies could be referred to as primary-group functions (Jenkins, 1981). These activities emphasized family and kinship supports, parental responsibility for children rather than institutional responsibility, maintenance of indigenous languages, provision of career advancement opportunities for clients, and accommodation of traditional myths to meet service needs.

Further, it was found that in addition to these primary group activities, these ethnic agencies were able to respond quickly and effectively to unexpected needs and multiple contingencies, both of which are typical of primary group functions.

Research findings confirm the view that if mental health practice is to be relevant and responsive to minorities, it must consciously and deliberately take into account their ethnic heritage and culture. This research also demonstrates specific ways by which ethnicity may be deliberately incorporated into practice. The lesson for social work and other mental health professionals is not to view the quest for including ethnicity in professional education and practice as a political demand or pressure of minority groups but to consider it as an important component in remedying serious deficits in training and traditional mental health practice.

The World Views of Minorities and Their Mental Health

The world views of minorities are useful as a source of information for assessing mental health status, for designing innovative programs, for assisting in the diagnosis and treatment planning process, and ultimately for leading to the empowerment of minority families and individuals. *(Note 10)* "World views" belong to a class of concepts which have been used to define ways in which people perceive their relationship to nature, institutions, other people, and objects. Most scholars suggest that world views constitute our psychological orientation in life and can determine how we think, behave, make decisions, and define events. Our cultural experience and life events influence

our world views. Value-orientations form critical components of an individual's world view (Kluckhohn and Strodbeck, 1961; Bibby, 1983; Meddin, 1975).

In the case of ethnic minorities, racism is a critical factor in determining world views. Thus, culture and racial-specific factors may interact in such a way as to produce persons with differing world views. Afro-Americans, Asian Americans, Mexican Americans, and Native Americans, therefore, have a high probability of holding simultaneously different world view perspectives.

The family and religion are central to the life of minorities and play major roles in shaping world views. Among Blacks, for example, the entire Black experience is understood in the idiom of kinship, and the church serves as an important institutionalized context for this drama. There is impressive evidence which suggests that when there is no accessible or localized kin group, one is invented (Stack, 1974; Shimkin, Shimkin and Frate, 1978). Increasingly, however, major social and economic hardships are making it difficult for the family and religion to play critical roles in shaping world views.

The world views of ethnic minorities can be divided into four major categories: 1) bicultural/multicultural, 2) acculturated/assimilated, 3) native-oriented/traditional, 4) transitional/marginal.

These dichotomized world views are drawn from a diverse literature on racial minorities and represent both cultural and structural dimensions of world views.

☐ *Bicultural/Multicultural* world view draws upon multiple sources of culture and socialization experiences. Bicultural world views result from experiences in two different ways of life for minorities—their own traditional culture and the mainstream cultural system. Concepts such as "duality," "two-ness," "double-consciousness," and "divided identity" have been used to describe the process which results in the synthesis of two distinctive cultural systems. There is an assumption that each culture is equal, hence there is no notion of cultural replacement (Valentine, 1971).

The multicultural aspect refers to the value placed upon pluralism in all cultural matters such as religion, custom, family structure and social identity. A person with a multicultural world view is able to retain a fair degree of what is distinctive and creative in his or her own cultural tradition. At the same time, she or he is able to draw from and

integrate diverse, cultural traditions of a pluralistic society. Both bicultural and multicultural perspectives are the opposite of the "melting pot" approach to peoples and cultures. The "melting pot" approach emphasizes assimilation. Its goal is to insist that individuals and groups divest themselves of their traditions and practices and to level differences between diverse cultural groups. Often this process is oppressive and arbitrary. The identification and loyalties of the person with a multicultural world view transcend the boundaries of own-groupness. Commitments are based on a vision of the world as a global community. *(Note 11)*

☐ *Acculturated/Assimilated* world view involves the acquisition of beliefs, attitudes and behaviors of a social group to which one is not a natural member. Acculturation as a process refers to the cultural level of the world view. It involves the extent to which members of an ethnic group take on the values, norms, and role expectations of the dominant group. In contrast, assimilation is an end state whose essence is the development of primary group ties with the mainstream or dominant group (Gordon, 1964).

☐ *Native-Oriented/Traditional* world view is based on patterns of behaviors, values, and beliefs of a group that shares a common historical past. Its core culture is not American mainstream, rather it is the mainstream of the native culture of the particular ethnic group under consideration. Fundamental to this perspective of ethnic culture as mainstream in itself is the position that minority culture has a core which is not based upon adaptation to harsh realities. Rather it is rooted in unique familial and communal experiences and history. Tradition-oriented primary group perspectives are emphasized, coupled with geographical isolation and influence by the family and extended kin group. Generally, contact with mainstream or dominant culture is marginal and the person lives in a world primarily restricted to the symbols and norms, behaviors, values, and beliefs of the traditional culture (Spindler and Spindler, 1957; Gwaltney, 1980). *(Note 12)*

☐ *Transitional/Marginal* world view refers to types of individuals who are suspended between their own ethnic identity and the mainstream culture. They are marginal persons with neither a strong identification with native/traditional nor mainstream, primary group

life. Although transitional/marginal world views are diverse, fundamentally they contain cultural content from their group of ethnic origin.

A Classification of World Views

Specific world views may be classified through the identification of their unique and salient characteristics. The descriptions of world views serve to establish their independence from each other. Since world views may overlap—an individual (or group) may hold one or more world views simultaneously—it is critical to establish their boundaries. In most cases, however, the expectation is that only one will predominate at any point in time.

Another consideration related to the task of establishing the specific boundaries of world views is the recognition that they are dynamic, open systems and are likely to change or be significantly altered over time. Yet, the direction of change is not easily predicted since a return to a traditional world view may be predicated on an ethnic identity or political ideological motivation. For example, many young Black and Hispanic people are deliberately choosing traditional cultural life styles over mainstream life styles which may have been acquired through educational and occupational mobility transformations or through social inheritance.

Thus, we assume that ethnic minorities may do things their own way, not just because they have been excluded from mainstream institutions by prejudice and discrimination, but because they find the values and institutions of the larger society less desirable than their own.

Factors producing changes in world views are found in two (2) sources of an individual's biography or group history. One set of factors is associated with the person's life cycle and includes such critical life events as birth, schooling, marriage, divorce or separation, retirement, and old age. The other factors are related to critical life events which are episodic in character and frequently create disruptions which require some form of adaptation or change. Job changes, relocation to another community, a major illness, or death of a loved one are examples of such episodic events. In addition to factors associated with

the life cycle and critical life events, world views are likewise shaped by such factors as age, place of birth, education, occupation, socio-economic status, and where a person lives and works. In sum, world views are determined by an assessment of the interaction between ethnic culture, mainstream American culture, and critical life events and experiences.

The process of identifying specific world views can be achieved by the cross-classification of two (2) dimensions: 1) the level of intensity and value an individual places on his/her own culture and identity, and 2) the level of intensity and value placed upon involvement and participation with the mainstream culture.

For descriptive purposes, these values can be expressed on a scale of "high" to "low." In the figure below, we see that they yield a four-celled typology of world views. A bicultural/multicultural world view is predicted to be held by individuals who are likely committed to both their own culture as well as mainstream culture (cell 1). In contrast, a transitional/marginal world view is likely to be held by persons with low commitments to both their own and mainstream cultures (cell 4). In between both of these extremes are the remaining world views which hold mixed values on the two dimensions. Acculturated/assimilated world views are characterized by a low level of commitment and involvement to one's own culture and a high commitment to the mainstream culture (cell 2). Native-oriented/traditional world views represent a commitment to one's own distinctive ethnic culture and origins with a lower commitment to the mainstream culture (cell 3).

A Typology of World Views

Level of Participation and Commitment to Mainstream and Other Cultures	Level of Participation and Commitment to Own Culture and Identity: High	Level of Participation and Commitment to Own Culture and Identity: Low
High	(1) Bicultural/ Multicultural	(2) Acculturated/ Assimilated
Low	(3) Native-Oriented/ Traditional	(4) Transitional/ Marginal

In the context of mental health, this typology of the world views of racial and ethnic minorities can serve at least three (3) major functions:

1. for assessing the basic orientations of individual, ethnic minorities and their relationship to their own racial, ethnic group and the larger society;
2. for avoiding two (2) types of errors:
   a) assuming racial and ethnic minorities are unicultural and
   b) assuming within racial, ethnic groups differences are "minor" variations on the mainstream theme; and
3. for providing a framework in consideration of related content in the life of ethnic minorities, such as language, forms of social life, voluntary associational ties, formal social and political organizational participation, residential patterns, attitudes, values, beliefs, norms, behaviors, and critical life events.

Concluding Remarks

Crosscultural efforts for mental health delivery systems have come of age. Ethnic and racial pride and identity have been a part of this process. Our interpretation of the role of ethnicity and world views builds upon new and emerging conceptualizations of the ethnic experience in the United States. It will require changes in the ways in which mental health professionals, service delivery systems, and educational programs interact with racial and ethnic minorities. Mental health problems of minorities can no longer be viewed in isolation from the rest of the society nor should there be much tolerance for the conditions which impact upon their mental health, especially racism and discrimination.

To ignore or fail to understand and consciously recognize the world views of minorities is to engage unwittingly or otherwise in a form of cultural oppression. When mental health practitioners fail to take into account world views of minorities or, in the absence of doing so, substitute their own views (especially when they differ from their clients), they are likely to impute negative traits to their clients and to contribute to the high drop-out rates of minority clients in mental health services.

Given our nation's long struggle with racism and social injustice, the mental health professions and the organized mental health service delivery system will take a giant step toward the promotion of mental health for all citizens when they are prepared to assume an unswerving commitment to racial justice. Such a commitment must encompass not only target interventions at the levels of research, treatment, system change, and community empowerment, but also what is more difficult—the willingness to adopt, for a period of years, a set of explicit policies and practices which will serve to eliminate the roots of racism in American society.

Notes

1. This history of the American Youth Commission is based upon a variety of sources but primarily on the studies and related documents produced by the project over its three year history. The four major studies of the project are cited in the text and include as well monographs by Robert L. Sutherland (1942) and Ira DeA. Reid (1940). Also see *The Hogg Foundation For Mental Health: The First Three Decades*, 1940-1970 (1970), especially "A Personal Reminiscence" by Homer P. Rainey.

2. 347 U.S. 486 (1954).

3. As part of my preparation for this lecture, I informally interviewed a number of former colleagues of Dr. Sutherland's at The University of Texas at Austin. These words summarize their sentiments.

4. It should be pointed out that the relationship posited between mental illness and racism relates to the quality of services, utilization of services, type of hospital admissions, type of treatment and the like, rather than to racial differences in mental disorders. As William A. Rushing indicates, there is no consistent evidence demonstrating such a relationship. See Rushing's discussion of this issue in footnote 5 of his article (1980).

5. The data cited below have been summarized and drawn from a plethora of research studies and theoretical works. The principal sources include: Willie, Kramer and Brown, 1973; Gary, 1978; President's Commission on Mental Health, 1978; Chesney and Engel, 1982; Jackson, 1976; Cole and Pilisuk, 1976; Cannon and Locke, 1977; Green, 1982; Cheetham, 1982; Jenkins, 1981; Parron, 1982; Pinderhughes, 1982; Yee and Hennessy, 1982.

6. This propositional statement is based upon the theoretical and research studies on the relations between families and other primary groups to large-scale bureaucratic organizations. See in particular Litwak, 1965; Litwak and Meyer, 1966; Litwak and Figueira, 1968; and Litwak and Meyer, 1974.

7. See Charles Kadushin's (1983) discussion on interpersonal environments and their mediating role between the larger society and the incidence of mental illness.

8. Nathan Glazer (1983) describes the history of ethnicity and ethnic self-consciousness in terms of waves and uses the analogies of crest and troughes to emphasize changes in the rise and fall of public consciousness about matters ethnic.

9. This point of view was vividly stated by Nathan Glazer and Daniel P. Moynihan in the first edition of *Beyond the Melting Pot* and radically altered in subsequent editions. This discussion is further complicated by a view which suggests that race is a declining influence in the economic marketplace. See William Wilson: *The Declining Significance of Race*. Second edition, Chicago and London: University of Chicago Press, 1978.

10. Strong research evidence suggests that personality, life style and world view factors play an important role in the utilization of health care. Such understandings can form an empirical basis for designing mental health programs for minorities. See Dawkins, Dawkins, and Terry (1979) and Dawkins, Terry, and Dawkins (1980).

11. The discussion on bicultural/multicultural world views is based upon two (2) different literature sources: social science and biographical and non-fiction writings of ethnic minorities. Important social science sources include Berry (1979), Blauner (1970; 1972), Valentine (1968; 1971), DuBois (1961), Spindler and Spindler (1957), Sue (1978), Sanders (1980), Polgar (1960). Biographical and non-fictional writings include Claude Brown (1965), Hansberry (1959), Rivera (1982).

12. The concept "native-oriented" world view is taken from the anthropological research of John L. Gwaltney (1980) which he describes as "native anthropology".

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